

serious adverse reactions that had occurred in certain patients taking terodiline for urinary incontinence.

As it is probable that many patients who discontinue terodiline will require an alternative treatment I am concerned that no advice on alternative treatment has been given to prescribers.

In view of the extremely long half life of terodiline, particularly in elderly people, there is a risk that if patients immediately start taking another agent with anticholinergic properties, such as Ditropan (oxybutynin), they may suffer severe anticholinergic side effects as effective levels of terodiline may persist in the blood for up to two weeks after treatment has been stopped, or even longer in the frail elderly.

It is therefore advisable for prescribers changing patients from terodiline to another treatment to consider a washout period of at least two weeks before starting treatment with other drugs with anticholinergic properties.

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SIR,—The recent publication of our paper¹ coincided with an interest in reports of cardiac arrhythmias associated with the use of terodiline, most notably torsades de pointes.² We could not show that terodiline conferred any additional benefit over bladder retraining in elderly patients with detrusor instability. Dr Gordon Boyd holds the view that our findings are less significant because of the inclusion of bladder retraining in our protocol.³ We do not agree; bladder retraining is a very simple, safe, and effective means of treatment.

The use of terodiline in older people requires very careful scrutiny. It has been shown to have a mean half life of 189 hours (SD 135, range 69–485 hours) in frail elderly people.⁴ A pharmacokinetic profile of this kind does not encourage confidence in the predictability of the risk-benefit balance. Recently the Drug Safety Research Trust reported on observations that suggest, in particular, an increased incidence of episodes of confusion, falls, and fractures in elderly patients taking terodiline when compared with a similar control sample of patients taking nabumetone.⁵ The article concludes with the observation that the problem may be larger than a handful of reports of torsades de pointes. We have considerable doubts over the justifications for using terodiline in the elderly.

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The health of the nation

SIR,—The Health of the Nation series has got off to an unfortunate start. The first article, by the Radical Health Statistics Group, presents such a negative, biased, and distorted picture of the consultation document that one could almost accuse the group of being party political.¹ Anyone reading the paper would indeed be left with the

impression that “all the components necessary for a national programme aimed at enhancing the nation's health are absent”; that the question of inequalities in health had been totally overlooked; and that the requirement to find new ways of measuring improvements in health had been omitted.

It seems only fair to point out that the authors of this article have deliberately ignored the paragraphs in the green paper which describe the need for government “to take effective action on behalf of individuals and their families”; identify how progress in addressing inequalities in health could be made; and outline a varied programme of research and development to support better monitoring of health in the future.²

By accusing the government of confusing a strategy for health with a strategy for the health service, it is clear that they themselves are confused. In claiming that the scope for improving health largely lies outside the NHS, they clearly do not understand that “health” is a multidimensional concept which includes, for example, enjoyment as well as duration of life; freedom from pain as well as relief from discomfort. They obviously have not registered, either, the growing responsibilities of health authorities to purchase a range of NHS and non-NHS services which achieve better health and to develop local health strategies with other agencies.

Some of the arguments which they use, supported by references,^{3,4} are no more than a collection of value judgments or half truths. Furthermore, no real solutions are put forward as alternatives to the many issues which are raised. Those of us “who have a heart to help” and not just censure the government's proposals for a national strategy for health will recognise the ease with which sneers or yawns can kill off new initiatives such as these.

Let us hope that the rest of the series will offer practical and constructive suggestions on what might be included in a future white paper and thereby make a genuine contribution to this important debate.

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SIR,—Dr S Bingham's response to *The Health of the Nation* discusses the role of government in food policy.¹ There is another area in which the government is able to influence food policy at no additional cost. The Common Agricultural Policy (CAP) now consumes over 30bn European currency units annually² (£1=1.43 ecus); much of this is spent in subsidising unhealthy foods. Two examples involving saturated fats are the payment on the butterfat content of milk and a minimum fat content for the top prices on animal carcasses. A third example is the subsidy on tobacco growing.

We are encouraged to drink skimmed milk and to trim excess fat off meat. It would be more efficient, and improve the nation's diet, if there was no incentive to produce excess saturated fat. If we are going to subsidise food production then the policy should also aim to improve health.

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New dietary reference values

SIR,—The panel on dietary reference values of the Committee on Medical Aspects of Food Policy, which reported on food energy and nutrients for the United Kingdom,^{1,2} should have dealt with fat with as much objectivity as it dealt with vitamin E and referred prevention of cardiovascular disease, cancer, obesity, and diabetes to a panel convened for the purpose. There is general agreement that experimental evidence from metabolic studies in patients with schizophrenia in institutions favours reducing saturated fatty acids in the diet to reduce a raised plasma cholesterol concentration.^{3,4} Genuine scientific controversy remains, however, over the ideal replacement for the energy derived from saturated fatty acids.

Although the 33% energy derived from fat is described as a dietary reference value for the population average, it was presented by the American Heart Association in 1968⁵ and the Committee on Medical Aspects of Food Policy in 1984⁶ as an upper limit, and health educators will continue to interpret it as such for individual people. There is no significant evidence, however, either that a limit for total fat intake is appropriate or that it should be one third of total energy intake, and neither the American Heart Association's rationale (with 168 references) for its diet-heart statement⁷ nor the Committee on the Medical Aspects of Food Policy in 1984 provided any supporting evidence.

This is not an academic quibble because when the National Institutes of Health's consensus development panel included limits on fat in a national recommendation on diet for everybody over 2 years old⁸ the American Academy of Pediatrics issued a statement that youngsters under 20 should be excluded because the diet was inadequate for growth, was untried, and might have unknown adverse long term consequences.⁹

The controversy is not yet resolved on how best to replace energy from discarded fatty acids because replacing these with carbohydrate, even complex carbohydrate, risks increasing low density lipoprotein triglyceride concentrations and, more importantly perhaps, reducing the concentration of high density lipoprotein.¹⁰ There seems to be no such disadvantage from replacing saturated fatty acids by monounsaturated fatty acids.

As has been apparent hitherto, nutritionists and health educators will invoke the authority of a government committee to promote a low fat diet for everybody and risk undernourishment of some children while increasing the risk for those already prone to coronary disease. The debate should not be stifled on the basis that it confuses consumers and undermines confidence in recommendations for healthy eating: the evidence is incomplete or conflicting, and recommendations have a habit of being reversed. There was a time when increasing polyunsaturated fatty acids in the diet was seen to be the recipe for a long and healthy life.

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- 7 American Heart Association Nutrition Committee. Rationale of the diet-heart statement of American Heart Association. *Circulation* 1982;65:839-54A.
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